



Chosen Health Care Institute, Inc.
8401 University Executive Pk. Dr. Ste 111
Charlotte, NC 28262
Phone (704) 547-1988 Fax (704) 547-5077

Start Date: ____/____/____
End Date: ____/____/____

Check one: Day () Evening ()

NAME OF PROGRAM ENROLLING IN: _____

Course Hours: _____ (Class: _____ Lab: _____)

**Chosen Healthcare Institute has the authority to review any special cases as well as the right to refuse enrollment to an applicant when it is in the best interest of the program or the applicant. Enrollment is due prior to the first day of class. Any enrollment received after will not be accepted.*

Enrollment Requirements:

- | | |
|--|---|
| ✓ Application | ✓ Physical Examination from health provider |
| ✓ Government issued ID w/Picture or Driver License | ✓ Tuberculosis (TB) Test/Chest X-Ray |
| ✓ Social Security Card | ✓ Back ground Check |
| ✓ High School or GED Transcript | ✓ Drug Test (Pharmacy Tech) |
| | ✓ Internship: Immunization Record |

Fees:

Non-refundable registration fee \$50.00. Program for CHCI is \$_____ Total payment are due prior to or before the first day of class. The student is responsible to pay for the North Carolina Certification Exam or NHA. The passing of the state exam depends on the student's ability and knowledge of their course. CHCI is not responsible for the failure of the state exam of the students.

Refund Policy:

Refunds will be issued on tuition and fees under the following circumstances:

- A 100% refund shall be made if the student officially withdraws from class before class begins or if class cancels due to insufficient enrollment.
- Refunds will be calculated from the date of withdrawal, which is the last date of actual attendance.
- Written notice of intent to withdraw must be given to the program director.
- Students will be allowed to re-enter the program at a convenient time whining six months or withdrawal at no extra cost
- No refund will be made after student who withdraws unofficially or who has been required to withdraw by the school.
- No refunds will be issued on the registration fee or books.
- No refunds will be issued to a student who was made to drop due to misconduct or poor progress.

Applicant Signature: _____ **Date:** _____

** Note: Please send a \$50.00 non refundable registration fee with this application. No personal check or cash accepted.*



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APPLICATION FOR REGISTRATION

Applications are considered without regards to race, religion, nationality, age or handicap.

Start Date: ____/____/____
End Date: ____/____/____

Check one: Day () Evening ()

NAME OF PROGRAM ENROLLING IN: _____

Course Hours: _____ (Class: _____ Lab: _____)

Name: (Last) _____ (First) _____ (Maiden) _____
(Print) (Print) (Print)

Address: _____ Apt _____

City: _____ State: _____ Zip _____

Telephone #: Home: () _____
Cell: () _____
Work: () _____

Email Address:

Emergency Contact:

Address:

Telephone #: Home: () _____
Cell: () _____
Work: () _____

Applicant Signature: _____ Date: _____



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APPLICATION FOR REGISTRATION (Continued)

Name of High School Attended _____

Address: _____

Did you graduated High School or received your G.E.D? YES () NO ()

Did you graduate College? YES () NO ()

Number of years of Education (Circle one):

8 9 10 11 12 High School Graduation Date: _____ College Graduation Date: _____

***Please provide a copy of High School or G.E.D. Transcript or College Transcript.**

Any other educational experience:

Are you currently in school?

If yes, Where? _____

Do you have you ever been convicted of Felony? () YES NO ()

If Yes, Explain in detail:

What are your career goals in the next 3-5 years?

Other Information (Health Care Experience)

Applicants Signature: _____ Date: _____



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APPLICATION FOR REGISTION (Continued)

TUITION: \$ _____ [INCLUDING THE \$ 50.00 REGISTRATION FEE (NON REFUNDABLE)]

Payment Choice: Cash: ____ Money Order/Cashier Check: ____ (NO PERSONAL CHECKS)

Registration Fee \$: ____ Date: ____ Receipt#: ____ CHCI Pep's Signature _____
 1st Installment \$: ____ Date: ____ Receipt #: ____ CHCI Pep's Signature _____
 2nd Installment \$: ____ Date: ____ Receipt #: ____ CHCI Pep's Signature _____
 3rd Installment \$: ____ Date: ____ Receipt#: ____ CHCI Pep's Signature _____

*Payments are strictly according to chosen plan. There is a service charge of \$ 10.00 when payment is made in installments and a late charge of \$25.00 in applicable to each late installment. Failure to pay appropriately will invalidate the contract / result to withdraw from class immediately.

SOURCE OF PAYMENT:

Personal: WIOA Vocational Rehab Other: _____

Applicants Signature: _____ *Date:* _____

Witness (School Official): _____ *Date:* _____